QualChoice® HEALTH INSURANCE

Product Selection & Sold Rate Form

This form must be filled out by **Renewing Groups** and **New Groups**.
New Groups must also fill out, sign, and attach the Group Application for Coverage.

Section I. Group/Plan Sponsor Information

Group/Plan Sponsor Name

Effective Date/Renewal Date (MM/DD/YYYY)	Name of Broker/Agent of Record	Agency Name

Section II. Medical Enrollment Count *This section is **required**, or form cannot be processed.*

IMPORTANT: For purposes of determining group size, the Patient Protection and Affordable Care Act ("PPACA") defines the number of employees as "the average number of employees employed by the company during the preceding calendar year." An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time, or seasonal status, or whether or not they have medical coverage.

Number of employees on the last day of each month divided by 12 for previous year: Average Total Number of Employees (ATNE) = _____

NOTE: If you are part of a controlled group or an affiliated service group, you may be considered an applicable Large Employer as defined by PPACA and subject to Large Employer underwriting and enrollment rules. If you are not sure, consult with your accountant regarding your employer status.

MEDICAL ONLY Provide current Employee Counts. (Full-time means an active employee working at least 30 hours/week and 48 weeks/year.)	**In State**	**Out of State**	**Total**
No. of Full-Time Employees Enrolling Coverage Include those satisfying their waiting period within 90 days after the effective date.			
No. of Full-Time Employees Declining Include those satisfying their waiting period within 90 days after the effective date.			
No. of Retirees eligible for coverage			
No. of COBRA or AR State Continuation Coverage enrollees			
Total Enrolling and Declining			
Part Time/Seasonal/Temporary Employees			
Total Number of Employees			

In the preceding calendar year, has the group had 20 or more employees on at least 50% of the group's working days? ☐ Yes ☐ No

Section III. ID Cards

If purchased, Medical and Dental ID cards are to be delivered to: ☐ Group Always ☐ Group (Initially) ☐ Individual

If purchased, Vision ID Cards are mailed to the member's address by Superior Vision (administrator of QualChoice Vision Benefits).

Section IV. Enrollment and Eligibility Rules.

Enrollment and eligibility rules apply to all ancillary products offered through QualChoice.

Are all employees covered by workers' compensation? ☐ Yes ☐ No

If YES, name of the workers' compensation carrier: _____

Please check the eligibility classes of employees for medical, vision, or dental coverage.

☐ Full-Time active employees. Full-Time is active employee working at least 30 hours/week and 48 weeks/year.

☐ COBRA. ☐ Retirees. Only available to groups of 100+ employees.

New Hire Enrollment For multiple waiting periods, please define employee class.	**Open Enrollment**	**New Groups Only**
Waiting Period *(Check One)* ☐ Date of Hire ☐ First of month after date of hire ☐ First of month after 30 days ☐ First of month after 60 days Class _____	☐ 30 days before renewal date ☐ Other (subject to underwriting approval). Explain below.	Are you waiving the initial waiting period? ☐ Yes ☐ No **NOTE:** Only applies to employees in their initial waiting period and would be effective on date of the group contract.
Waiting Period *(Check One)* ☐ Date of Hire ☐ First of month after date of hire ☐ First of month after 30 days ☐ First of month after 60 days Class _____		

Effective Date for Rehires	**Termination Date**
☐ No rehire policy. Employee must fill out waiting period as new hire. ☐ Effective date is first of the month following rehire date. ☐ No. of months between termination date and rehire date. Please fill in no. of months or check no. of months. _____ months • No. of Months: ☐ 3 months ☐ 6 months ☐ Rehire Policy, Other _____ **NOTE:** If rehire date is greater than 6 months from termination date, employee is subject to new hire waiting period. Large groups may be subject to penalties under the employer-shared responsibility mandate if certain rehired employees are required to complete a waiting period.	Termination date will be on the last day of the month of termination for employees or dependents

Section V. Employer Contribution

% of Employee Only: _____ % (cannot be less than 50%) or $ _____ PEPM	% of Dependents: _____ %

Section VI. Medical Plan Selection

Depending on the type of health plan your group falls under, complete and submit one of the following attachments with your form.

Attachment 1: Non-Grandfathered Small Group (2-50 eligible employees) Plan — *ACA Metallic Plans*

Attachment 2: Grandfathered Small or Large Group Plan — *Not available for purchase with ACA Metallic plans*

Attachment 3: Non-Grandfathered Small or Large Group Plan — *Non-Metallic Plans — Not available for purchase with ACA Metallic plans*

Section VII. Ancillary Products

Group Term Life and AD&D ☐ YES ☐ NO	Amount of Coverage Selected: $_____ Total PEPM Amount: $_____ PEPM	
	Multiple of Salary ☐ _____ x annual salary up to $100,000 ☐ _____ x annual salary up to $100,000	**Class Description** (if applicable)
Dependent Life ☐ YES ☐ NO	☐ Spouse $2,500/Children $2,500 ☐ Spouse $5,000/Children $5,000 ☐ Spouse $7,500/Children $7,500 ☐ Spouse $10,000/Children $10,000 **IMPORTANT:** Dependent life amount cannot be more than 50% of employee amount.	

Group Term Life and AD&D benefits reduce 35% at age 65, 50% at age 70, and 70% at age 75. Employee must be actively at work on his/her effective date for Group Term Life and AD&D coverage to take effect. QualChoice Life and Health Insurance Company, Inc. is an independent company and operates separately from QCA Health Plan, Inc. QCLHIC is solely responsible for life insurance.

Section VIII. Ancillary Products (cont'd)

Dental Benefits ☐ YES ☐ NO	Plan ID No._____ Is dental coverage a medical match: ☐ YES ☐ NO			Selected rates (rates based on selected tier) ☐ 2 Tier Rates ☐ 3 Tier Rates ☐ 4 Tier Rates		
Employer Dental Contribution	% of Employee Only	% Dependents	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
			$	$	$	$
QualChoice Vision Benefits ☐ YES ☐ NO	Plan ID No._____ Is vision coverage a medical match: ☐ YES ☐ NO			Selected rates (rates based on selected tier) ☐ 2 Tier Rates ☐ 3 Tier Rates ☐ 4 Tier Rates		
Employer Vision Contribution	% of Employee Only	% Dependents	Employee Only	Employee & Child(ren)	Employee & Spouse	Employee & Family
			$	$	$	$

Section IX. Authorization and Signatures

On behalf of the Group/Plan Sponsor, the undersigned agrees and attests the following:

- That the information entered on this Product Selection & Sold Rate Form is correct and complete.
- That submission of a Product Selection & Sold Rate Form containing a false statement, material misrepresentation, or omission constitutes insurance fraud and may result in termination of coverage. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- That coverage will not be effective prior to written approval from QualChoice, and current coverage should not be cancelled prior to such approval.
- That the Group/Plan Sponsor agrees to the terms of the Group Master Contract and further agrees that this Product Selection & Sold Rate Form will be part of the agreement between the Group/Plan Sponsor and QualChoice.
- That, consistent with the requirements of the Genetic Information Nondiscrimination Act of 2008, QualChoice does not use genetic information for underwriting purposes, or any other purpose prohibited by applicable law. The undersigned acknowledges that, as part of the application process, QualChoice requested that it not be provided with any plan participant's family medical history or any plan participant's information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which the participant believes he/she may be at risk for.
- That as the authorized representative of the Group/Plan Sponsor, you confirm receipt and accuracy of the conditions and assumptions made by QualChoice as set out in the fully insured proposal/quote. You further acknowledge that the final sold rates and benefits issued by QualChoice were based on these conditions and assumptions. You agree that if it is subsequently determined that any of these conditions and assumptions are incorrect, QualChoice has the option to immediately either retrospectively modify the rates and benefits provided or terminate the Group Master Contract.
- QualChoice disclosure regarding producer compensation: Brokers and agents (referred to collectively as "producers") may receive commissions and other compensation from us, and these costs may be reflected in your premium or fee. Separately, you may have contracted with producers to provide services directly for your group and have to pay them a service fee. Since service fees are not a contingency of the purchase of health insurance, such fees are not part of your premium but may be included in your bill under Total Amount Due. In addition, we may pay bonuses pursuant to programs established to encourage theintroduction of new products and provide incentives to achieve production targets, persistency levels, growth goals, or other objectives. Bonus expenses are not directly reflected in the premium rate but are included as part of general administrative expenses. At your request, a service fee to be paid to your producer/service agent will be added as an expense item where service fees apply.
- Producer compensation for large groups (100+) may be subject to disclosure on Schedule A of the ERISA from 5500 for customers governed by ERISA. We provide Schedule A reports to our customers as required by applicable federal law. For specific information about the compensation payable with respect to your particular policy, please contact your producer.

Print Legal Name	Title
Signature	Date (MM/DD/YYYY)
Approved by Broker/Agent or QualChoice Representative – PLEASE PRINT NAME	Title
Signature	Date (MM/DD/YYYY)

POS and HMO plans underwritten by QCA Health Plan, Inc. | PPO plans underwritten by QualChoice Life and Health Insurance Company, Inc.
Group Term Life and AD&D and Dental Benefits underwritten by QualChoice Life and Health Insurance Company, Inc.
Vision Benefits underwritten by National Guardian Life Insurance Company. Administered by Superior Vision

QualChoice® HEALTH INSURANCE

Authorization for Automatic Payments — Group

ACH Debits

PLEASE PRINT

Section I. Group/Plan Sponsor Information

Name of Group/Plan Sponsor	Name of Authorized Group Representative	Phone No.

Authorization for Automatic Payments

I authorize QualChoice to debit from our group bank account the amount necessary to pay the monthly premium owed under our group's QualChoice contract. This authority will remain in effect until I, or another authorized group representative, notify QualChoice, or the bank/financial institution listed below in writing to cancel it in such time (30 days) as to afford the bank a reasonable opportunity to act on the cancellation.

Section II: Bank/Financial Institution Information

Name of Bank/Financial Institution	City	State	Zip Code

Please deduct our group's monthly premium from (check one): ☐ Checking ☐ Savings

Account Number:	9 Digit Routing Number:

Signature of Authorized Group Representative	Date (MM/DD/YYYY)

Section III: Account Holder Information

Print Name of Authorized Account Holder

Signature of Authorized Account Holder	Date (MM/DD/YYYY)

Section IV: Instructions

Mail: QualChoice
ATTN: Finance Dept.
P.O. Box 25610
Little Rock, AR 72221

Fax: 833.681.2496

Email: qca_finance@qualchoice.com

If you have any questions, or if there is a change in your banking information, please call:

QualChoice Finance Department, 501.228.7111 or 800.235.7111

Monday-Friday, 8:00 a.m. to 5:00 p.m., Central Time

Plan Selection ATTACHMENT 1

Non-Grandfathered Small Group*: ACA Metallic Plans

Not available for purchase with non-Metallic plans
**2-50 eligible employees*

Name of Group/Plan Sponsor: _____

NOTE: If offering more than two (2) options, this form may be copied as needed. Multiple plan options may be offered only if the same type – all POS or all PPO, all QCNN or all non-QCNN.

Point of Service (POS) Plan

Option 1	**Option 1 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $_____ ☐ Age Rates ☐ Composite Rates
Option 2	**Option 2 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $_____ ☐ Age Rates ☐ Composite Rates

Preferred Provider (PPO) Plan

Option 1	**Option 1 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $_____ ☐ Age Rates ☐ Composite Rates
Option 2	**Option 2 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $_____ ☐ Age Rates ☐ Composite Rates

NOTE: Pediatric Dental was included in your original quote. The Affordable Care Act requires that to purchase a medical plan without pediatric dental, the group must provide a Qualified Health Plan Stand-Alone Pediatric Dental Plan to your employees.

Grandfathered Small or Large Group

Not available for purchase with ACA Metallic plans

Name of Group/Plan Sponsor: _____

NOTE: If offering more than two (2) options, this form may be copied as needed. Multiple plan options may be offered only if the same type – all POS or all PPO.

Point of Service (POS) Plan

Option 1	**Option 1 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $_____ ☐ Age Rates ☐ Composite Rates
Option 2	**Option 2 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $_____ ☐ Age Rates ☐ Composite Rates

Preferred Provider (PPO) Plan

Option 1	**Option 1 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $_____ ☐ Age Rates ☐ Composite Rates
Option 2	**Option 2 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $_____ ☐ Age Rates ☐ Composite Rates

Medical Optional Benefit Riders

You must elect or reject each rider. *By electing any of the following benefit riders, premiums will be adjusted accordingly.*		**Mandated Offer**	**Elect**	**Reject**
POS and PPO Plans	**Temporomandibular Joint (TMJ) Disorder**	☐	☐	☐
PPO Plans	**Hearing Aids and Hearing Instruments Benefits**	☐	☐	☐

Plan Selection ATTACHMENT 3

Non-Grandfathered Small or Large Group: Non-Metallic Plans

Not available for purchase with ACA Metallic plans

Name of Group/Plan Sponsor: _____

NOTE: If offering more than two (2) options, this form may be copied as needed. Multiple plan options may be offered only if the same type – all POS or all PPO.

Point of Service (POS) Plan

Option 1	**Option 1 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $ _____ ☐ Age Rates ☐ Composite Rates
Option 2	**Option 2 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $ _____ ☐ Age Rates ☐ Composite Rates

Preferred Provider (PPO) Plan

Option 1	**Option 1 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $ _____ ☐ Age Rates ☐ Composite Rates
Option 2	**Option 2 Rates**
Medical Plan ID _____	Enter the monthly premium below from the Medical Quote and attach the Underwriting Rate Table. Monthly Premium $ _____ ☐ Age Rates ☐ Composite Rates

Medical Optional Benefit Riders

You must elect or reject each rider. *By electing any of the following benefit riders, premiums will be adjusted accordingly.*		**Mandated Offer**	**Elect**	**Reject**
POS and PPO Plans	**Temporomandibular Joint (TMJ) Disorder**	☐	☐	☐
PPO Plans	**Hearing Aids and Hearing Instruments Benefits**	☐	☐	☐